

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS644HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/18/2010
NAME OF PROVIDER OR SUPPLIER HORIZON SPECIALTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 640 DESERT LANE LAS VEGAS, NV 89106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 8/18/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.</p> <p>The facility was surveyed following the 2006 edition of the American Institute of Architects (AIA) Guidelines for the Design and Construction of Health Care Facilities and the 2006 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code.</p> <p>Complaint #NV00026213 was substantiated with deficiencies cited. (Refer to Tag S 0153)</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The following regulatory deficiencies were identified:</p>	S 000			
S 153 SS=A	<p>NAC 449.332 Discharge Planning</p> <p>11. The patient, members of the family of the patient and any other person involved in caring for the patient must be provided with such information as is necessary to prepare them for the post-hospital care of the patient.</p> <p>This Regulation is not met as evidenced by: Based on interview, record review and document review, the facility failed to follow their Unplanned</p>	S 153		9/7/10	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 153	<p>Continued From page 1</p> <p>Transfer of patient to Acute Hospital for Patient #1.</p> <p>Findings include:</p> <p>1. There was no documented evidence the family was notified of the patient's transfer to an acute hospital in the patient's medical file.</p> <p>Severity: 1 Scope: 1</p>	S 153			

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